WORLD HEALTH ORGANIZATION

TOBACCO ALERT

JULY 1992

EDITOR'S NOTE

WHO PARTICIPATION IN THE EIGHTH WORLD CONFERENCE ON TOBACCO OR HEALTH

The Eighth World Conference on Tobacco or Health featured a concerted contribution from the WHO Programme on Tobacco or Health (WHO/TOH), which was representative of all its programme areas and all WHO regions. National tobacco or health focal points (e.g. from Bangladesh, Botswana, Egypt, India, the Islamic Republic of Iran, Nepal, Sudan, Thailand) were invited by the WHO regional offices to Buenos Aires, and their contribution throughout the Conference enhanced WHO policy by presenting examples of the specific aspects of the tobacco control activities in their countries.

This issue of *Tobacco Alert* features highlights of this WHO contribution, as well as elements of research that led to the numerous presentations given by WHO/TOH and IARC staff members. It should also be mentioned that the involvement of WHO was made even more evident by a successful exhibition held in the lobby of the main conference area; more than 600 kg of WHO documentation was "scavenged" during the first two days.

The limited space in this issue of *Tobacco Alert* prevents us from doing justice to all WHO/TOH activities during the Conference and the Editor apologizes to those whose contributions cannot be featured in full. One such activity was the pre-conference meeting of "Dentists in tobacco control" under the dynamic leadership of Dr Mecklenburg. TOH staff also participated in other pre-conference meetings; of particular interest was that of the International Network of Women Against Tobacco (INWAT).

8th WORLD CONFERENCE on SMOKING or HEALTH

Building a Tobacco-Free World

As a logical conclusion to the Conference, the last day was dedicated to strategic planning sessions where individual countries, region by region, were encouraged to develop tobacco or health plans of action. During these strategic planning sessions, WHO endeavoured to bring all the benefit of its experience to these countries. Prior to the Paris Conference in 1994, it is expected that WHO will continue to collaborate with individual countries as well as NGOs in elaborating tobacco or health plans of action and/or national programmes so that once again, as was done in the period between Perth and Buenos Aires (see Editorial), noteworthy progress will be made between Buenos Aires and Paris.

IN THIS ISSUE

EPIDEMIOLOGY 2, 12
WOMEN AND TOBACCO 3
NATIONAL PROGRAMMES 4
ECONOMICS 5
SURVEYS 5
POLICY 6, 9
IARC 8
HEALTH EDUCATION 8
WORLD NO-TOBACCO DAYS 10
WHO PROGRAMME 12

EDITORIAL

BUILDING ON SUCCESS - FROM PERTH TO BUENOS AIRES

At the Seventh World Conference on Smoking and Health, held in Perth in 1990, a challenge was issued to those seeking to reduce smoking around the world. This challenge underlined that what really matters is the future and that although we cannot help the current 8 000 a day who die from smoking, we can help prevent many of the 28 000 deaths a day from smoking which we are going to see in the future if smoking patterns do not change.

Two years later, the Eighth World Conference on Tobacco or Health, in Buenos Aires, was reminded from the outset, by both the Director-General of WHO and the US Surgeon General, of the sheer magnitude of the problem. This year some three million people will die worldwide because they smoked; but by the time the children of today reach middle age the figure will have risen to an even more awesome ten million because greed has triumphed over public health.

At the Conference, we rightly focused on the challenges ahead but we should also remind ourselves of the progress already achieved, particularly in the following areas:

- The first World Conference to be held in a developing country (Argentina) showed that remarkable progress has been made in coordinating and developing action in Latin American countries.
- There is much evidence within most of the 83 countries represented at

(continued on page 2)

EDITORIAL

BUILDING ON SUCCESS - FROM PERTH TO BUENOS AIRES

(continued from page 1)

the Conference of genuine coalitions being developed to combat the smoking problem; no longer are health and community groups within these countries working in isolation. Similarly, there has been a welcome and rapid consolidation of international coordination between governments, WHO, smoking and health organizations and activists. Much better networking now exists than ever before; we have not only regional and national plans of action but also special interest groups covering a wide range of themes.

- The focus on women has become a key theme in many smoking control strategies. The percentage of women speakers at world conferences rose from 10% in Perth to 30% in Buenos Aires.
- There has also been progress in terms of specific campaigns. In every continent, campaigns have been successful in publicizing the smoking problem, influencing decision-makers, and often achieving legislation.
- The campaign for clean indoor air has accelerated around the world. The evidence of the damage to health caused by passive smoking has become, in the words of a leading US campaigner, "stronger than we ever wanted". This evidence, the commitment of WHO governing bodies, outstanding campaigners, litigation in several countries and the sheer pressure of public opinion are forcing changes that would have been unthinkable a few years ago.
- Perhaps most important of all is the fact that in a small number of countries where smoking control action has been under way for some time, and where smoking is declining, we are at long last beginning to see a decline in some of the diseases caused by smoking. The beginning of the downward curve for lung cancer and other diseases such as stroke and coronary heart disease is proof that we are moving in the right direction, an inspiration to move further and faster.

Nonetheless, in no country can there be any room for complacency; by the time of the next World Conference on Tobacco and Health (Paris, 1994), at least another six million people worldwide will have died because they smoked. And if health workers the world over do not act to halt this epidemic, who will?

Michael Daube
Chairman, Australian Council on Smoking and Health
Perth, Western Australia

EPIDEMIOLOGY

COLLECTING DATA IN DEVELOPING COUNTRIES: MORTALITY AND MORBIDITY

A skills-sharpening session on this topic was jointly chaired by Dr Alan Lopez (WHO/TOH) and Dr Sylvia Robles (Pan American Sanitary Bureau). Mortality and morbidity data relating to tobacco use are a fundamental component of epidemiological surveillance of the tobacco epidemic. The session began with an overview of the traditional approaches to the collection of mortality and morbidity data. These include:

- vital registration (this is operational in many developing countries but the reliability of the data is seriously affected by under-reporting of deaths and the low level of medical certification of the cause of death in many countries. Vital registration is also comparatively expensive.);
- hospital/clinic records (these have the advantage of providing information on morbidity as well as mortality from tobacco use, but are affected by biases in coverage since they are derived from attendance records. Population exposed to risk is often very difficult to define.);
- sentinel sites/primary health care centres (these community-based approaches are more likely to obtain community support and hence the degree of under-reporting might well be less than in other systems. Their principal drawback is the lack of diagnostic specificity which often arises from "lay" reporting based on disease symptoms.);
- health surveys (either single-round or multi-round surveys of selected households with retrospective reporting by family members on deaths due to tobacco use. These surveys are probably the most cost-effective approach for developing countries to obtain relevant mortality and morbidity data in the short term for monitoring the health effects of tobacco use. Surveys allow the collection of related socio-economic information as well as data on tobacco use. Their principal limitations are lack of diagnostic accuracy if non-medically trained interviewers are used, difficulties in determining the population at risk for rate calculations, and recall error about symptoms present at or around the time of death.).

A number of issues with regard to data quality assessment were also discussed, including the need to estimate the completeness of the mortality recording system (i.e. degree of under-reporting), possible sources of diagnostic error in determining the cause of death or illness (many tobacco-related diseases exhibit similar symptoms), and biases arising from the lack of comparability of data collected over several years.

The session concluded with a series of practical examples of the use of mortality data to monitor the health effects of smoking. These examples emphasized the need to collect data separately for males and females, as well as for broad age groups. Various approaches to the prudent use of incomplete or unreliable data for monitoring diseases due to tobacco use were also presented, including the use of truncated data sets to exclude mortality at older ages where the proportion of ill-defined causes is often very high.

WOMEN AND TOBACCO

BUILDING WOMEN'S LEADERSHIP IN TOBACCO CONTROL

Skills-sharpening session with the participation of Deborah McLellan, American Public Health Association (APHA), Vera Luiza da Costa e Silva (Brazil), and Claire Chollat-Traquet (WHO/TOH)

As an introduction to the session, a summary of the findings of the Tobacco or Health programme's monograph on "Women and Tobacco" was presented.[1] The first of these findings was the general lack of data and information that existed on women and tobacco other than in developed countries. Throughout the world, however, tobacco consumption rates are very diverse. In most developing countries, female consumption is still very low, except for chewing in the Indian subcontinent and in parts of Africa. However, in many countries there is a visible increase in tobacco consumption, especially by young women. This is well exemplified by smoking rates for women in Spain (Figure 1), a country where, traditionally, women did not smoke. What is more worrying is the fact that the increase in these countries is not matched by a real decrease in other countries and that, generally speaking, the decrease in women smoking is slower than the decrease in men.

The effects of tobacco consumption in women are similar to those in men: lung and other cancers, cardiovascular diseases, and chronic respiratory diseases (Figure 2). There are, however, more specific risks linked to women smoking, for example, pregnant women who smoke run increased risks of delivering low birth-weight infants. The socio-economic consequences of tobacco addiction are also important for women; the reality of poor women smoking is nothing like the sexy image portrayed by tobacco advertising. In fact, it is currently women with low incomes or low standards of education who are smoking in developed countries, while in many developing countries tobacco consumption can have a critical effect on the inadequate income of many families, and is often given a higher priority than food.

Action to curb the tobacco epidemic in women and prevent it reaching the same proportions as in men should be taken immediately, while simultaneously the monitoring of the epidemic pursued, and further assessment of the medical and behavioural aspects should be carried out. The recommended strategies included better utilization of very scarce resources.

The session then focused attention on the tools necessary for women's leadership in tobacco control. The first tool identified was the **knowledge** needed to influence the appropriate policies, such knowledge relating not only to epidemiology (prevalence, morbidity and mortality), but also the behavioural determinants of a woman's decision to use tobacco, i.e. what motivates her to start and stop. Advertising and promotion techniques used by the tobacco industry (such as the misuse of women's desire to be liberated, in order to gain profits) must be understood. So must other techniques of production promotion, such as the tobacco industry's sponsorship of women's organizations and sports, or self-censorship in women's magazines that accept tobacco advertising. Socio-economic and cultural aspects which may influence women to smoke must be known and addressed; otherwise, it is very difficult to prevent women from smoking, or to encourage them to give up. To this effect, women-centred prevention and cessation programmes were considered to be indispensable.

The group addressed, at length, the **roles** women have in today's society which might support women's leadership in tobacco control, such as their caring role in the family. However, some conditions were preventing women's role as leaders, for example, many of them had little economic or political credibility; one of the overwhelming factors, acknowledged by all participants, was the lack of time for most women, even motivated ones, because of competing demands for work, family and other occupations.

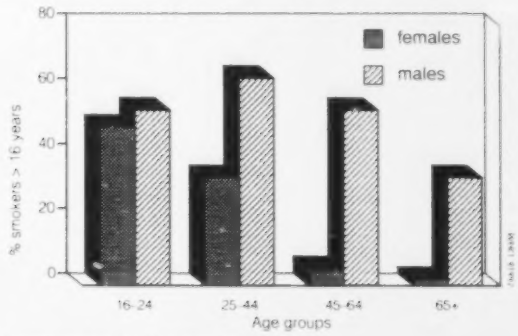
The necessary **skills** required to be a leader were analysed both from a formal and informal educational point of view. Professional training, such as scientific writing, public speaking, media advocacy, and fund-raising were considered important, as was personal training, particularly increasing self-esteem and self image. Time management and stress management were emphasized.

Great emphasis was put on the creation of **networks** as a means of decreasing women's inequality in different parts of the world and of increasing women's leadership potential. These networks were seen as a way of exchanging information, and of building coalitions with other groups concerned not only with tobacco but also with health, women's issues, civil rights and all broader social justice issues, aiming to save funds and to enlarge the power base of these movements. The capacity of networks and coalitions to transfer wealth (knowledge and resources) from richer countries and to share it with less affluent countries was the concluding theme.

The workshop concluded with a rapid overview of steps women could take to be involved in tobacco control in their own countries.

This monograph can be ordered from Distribution and Sales, WHO, 1211 Geneva 27, Switzerland

Distribution of smokers by sex and age in Spain, 1987



Source: National health survey, 1987.

Figure 1

Estimated cause of death distribution of mortality among women from smoking, all developed countries, 1985

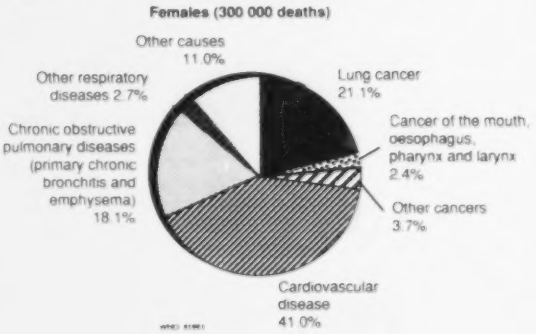

Females (300 000 deaths)
Other causes 11.0%
Other respiratory diseases 2.7%
Chronic obstructive pulmonary diseases (primary chronic bronchitis and emphysema) 18.1%
Lung cancer 21.1%
Cancer of the mouth, oesophagus, pharynx and larynx 2.4%
Other cancers 3.7%
Cardiovascular disease 41.0%

Figure 2

READEX FICHE

NATIONAL PROGRAMMES

TOBACCO OR HEALTH: STATUS IN THE AMERICAS
(Pre-conference meeting)

This meeting was held on 30 March 1992 to inform delegates of the findings of two new publications that resulted from a major collaborative undertaking between the United States Centres for Disease Control (CDC) and the Pan American Health Organization (PAHO). The first of these, *Smoking and Health in the Americas: A 1992 Report of the Surgeon General, in collaboration with the Pan American Health Organization*, was discussed by Dr Antonia Novello, the United States Surgeon General, and other members of the writing and editorial team. This report provides a broad overview of information about smoking and health issues in the Americas. From the report's major conclusions (see box), it is clear that no country of the Americas is immune to the tobacco epidemic.[2]

Smoking and health in the Americas: Major conclusions

1. The prevalence of smoking in Latin America and the Caribbean is variable but reaches 50% or more among young people in some urban areas. Significant numbers of women have taken up smoking in recent years.
2. By 1985, an estimated minimum of 526 000 smoking-attributable deaths were occurring yearly in the Americas; 100 000 of these deaths occurred in Latin America and the Caribbean.
3. In Latin America and the Caribbean, the current structure of the tobacco industry, which is dominated by transnational corporations, presents a formidable obstacle to smoking-control efforts.
4. The economic arguments for support of tobacco production are offset by the long-term economic effects of smoking-related disease.
5. Commitment to surveillance of tobacco-related factors – such as prevalence of smoking; morbidity and mortality; knowledge, attitudes, and practices; tobacco consumption and production; and taxation and legislation – is crucial to the development of a systematic programme for prevention and control of tobacco use.

Attention then turned to the companion volume entitled *Tobacco or Health: Status in the Americas*.[1] This report, to be published in 1992 by PAHO, was discussed by members of the editorial team that prepared it. The report was prepared under the general direction of Dr Carlyle Guerra de Macedo, Director, PAHO.

This report, nearly 400 pages in length, is a rich resource document, with each chapter devoted to a detailed status report of the tobacco or health situation in each of the countries of the Western Hemisphere, except the United States. Detailed information on that country is available from previous US Surgeon General's reports. In all, information is presented on 47 countries, colonies, departments and territories of North and South America.

For some areas, such as Canada, as well as the French departments of French Guiana, Martinique and Guadeloupe, there was clear evidence of encouraging progress in tobacco control. For other countries, however, the findings were much more sobering and emphasize the need to urgently enhance the effectiveness of tobacco control programmes.

[2] *Copies of the report (in English and Spanish) can be obtained from the United States Centers for Disease Control in Atlanta, Georgia, USA (US Department of Health and Human Services Publication No. (CDC) 92-8419.*

[1] *After publication in mid-1992, both English and Spanish versions of the report can be obtained from the PAHO office in Washington, DC, USA (Scientific Publication No. 536).*

PRE-CONFERENCE MEETING OF WHO AND REPRESENTATIVES OF MINISTRIES OF HEALTH
(Coordinated by Dr J.R. Menchaca (WHO/TOH), Dr H. Restrepo (PAHO/WHO), and Dr E. Nicholls (PAHO/WHO))

Participants were informed of WHO's tobacco or health plan of action and the most important activities recently developed in the different programme areas. Health promotion aspects related to tobacco use were largely addressed, emphasizing educational and other preventive measures to counteract the adverse effects of tobacco.

The meeting was enriched by the very interesting experiences presented by the regional offices and country representatives, which highlighted: the analyses of the tobacco consumption situation and of the tobacco control programme and plan of action in the Americas; the regional plan of action of the WHO Regional Office for Europe; present situation of tobacco use and control programmes in Eastern Europe; the effects of tobacco advertising in Thailand; tobacco consumption trends in the Eastern Mediterranean Region; short- and medium-term effects of tobacco use in India; tobacco marketing in Nepal; and the counteracting of aggressive tobacco advertising in Venezuela.

It was concluded that there is sufficient information to expect a worldwide increase in tobacco-attributable diseases if energetic measures are not taken. Successes achieved through global, regional and national plans of action demonstrate the usefulness of the implementation of comprehensive tobacco control programmes. To strengthen these programmes, WHO activities at all levels should concentrate on: improving data collection and exchange of information; developing intersectoral and multidisciplinary efforts; developing and implementing health policies, including legislative measures for tobacco control; improving school health education; obtaining wide support and participation of the general public and decision-makers; and emphasizing partnership and coalitions of all involved in the fight for a tobacco-free society.

ECONOMICS

CIGARETTE SMUGGLING IN CANADA

(Scientific presentation by Mr N. Collishaw (WHO/TOH))

Canada recently implemented comprehensive tobacco control policies that include, among many other measures, a ban on tobacco advertising, and high taxes on cigarettes. These high tobacco taxes in Canada and low tobacco taxes in the United States have led to a situation where, by mid-1991, 10% of Canadian cigarettes were exported to the United States, and then re-imported into Canada, many of them illegally, as a way of avoiding high Canadian cigarette taxes. The rapidly increasing illegal trade in cigarettes had a small but measurable effect in slightly slowing a long-term trend of rapidly declining tobacco consumption.

However, the study also illustrated the importance of carefully monitoring tobacco control activities, and quickly taking corrective action when policies or programmes are compromised. In this case, careful monitoring was vital in determining the size and nature of the problem. It was found that cigarette re-importation was growing exponentially and had reached 10% of cigarette consumption by mid-1991. Moreover, it was clear that virtually all of the cigarettes were being smoked by Canadians, and that Canadians were very unlikely to switch from their familiar straight flue-cured cigarette brands to the different tasting blended tobaccos, characteristic of American brands.

In these circumstances, the Canadian government acted in February 1992 to correct the problem by placing a tax of CAN $ 8.00 per carton of 200 cigarettes on cigarettes exported from Canada. New export taxes also applied to other tobacco products. As well, further restrictions were placed on duty-free imports of cigarettes and surveillance and enforcement of customs regulations were increased. These corrective measures have restored the effectiveness of tobacco taxation as an important tobacco control measure in Canada.

Based on a sound understanding of the problem, the government was able to identify and quickly implement this corrective action. Similarly, in Canada and elsewhere, careful monitoring of tobacco taxation and other aspects of tobacco control policy can help in maintaining policy effectiveness.

SURVEYS

SURVEILLANCE AND ANALYSIS OF SMOKING PREVALENCE

In a skills-sharpening session, Dr Pål Kraft, Mr Neil Collishaw (both of the WHO Tobacco or Health programme), and Dr Ines Salas from the University of Chile in Santiago, offered a short presentation on some of the important factors to remember when carrying out sample surveys of the population. The presentation emphasized the importance of constructing probability surveys (where these are feasible) in such a way that every individual in the population being surveyed has an equal chance of appearing in the survey. The fact that survey questionnaires on smoking prevalence need not be elaborate was highlighted. In fact, by sticking to just the few standard questions needed to elicit information on smoking behaviour, information on smoking can often be collected as part of larger, multipurpose surveys. The panel's presentation was completed by pointing to the challenges and difficulties in individual countries and the ways of overcoming these obstacles, based on the example of smoking prevalence surveys that had been carried out in Chile.

In the discussion that followed, it was concluded that sample surveys of smoking prevalence are an important tool in monitoring the extent of tobacco consumption. Surveys, however, are only one tool among many needed for monitoring a country's tobacco or health situation. Moreover, it is important that surveys be done properly to avoid biases due to unrepresentative sampling of the population, and that the results be carefully scrutinized for possible errors of reporting or interpretation. Surveys that are properly carried out, with correctly interpreted and reported results, can be powerful tools to guide the formation of national tobacco control policies.

POLICY

OPENING SESSION AND PANEL OF MINISTERS OF HEALTH

Dr H. Nakajima, Director-General, World Health Organization, and Dr C. Guerra de Macedo, Regional Director AMRO/WHO and Director PAHO, participated in the opening session of the Eighth World Conference on Tobacco or Health. The following are extracts from Dr Nakajima's statement at the opening session.

"Two years after meeting in Perth we are reunited, to determine progress, and how future joint activities can further our hope of providing a safer and healthier environment, free from tobacco smoke.

Over the past few years, the movement for the protection and promotion of health has gained momentum. Yet each year, three million people still die as a result of tobacco-related diseases. It is projected that, if control measures on a wider scale are not undertaken urgently, within the next few decades the annual death rate will be 10 million. For the sake of our children and future generations, this cannot be allowed to happen.

In an effort to control the pandemic, the World Health Organization has taken the lead in the development of measures for the use of individual countries. In this it has had the support of other international organizations, nongovernmental organizations and lesser known, but equally courageous and efficient, national groups and individuals.

...

At national and international levels, tobacco control is constantly faced with the power of an industry which has often managed to block or counter essential public health action. The profits at stake for the tobacco industry are enormous, but so too are the health risks for the population of the world. It is not acceptable that, together, the five largest multinational tobacco companies have annual revenues from their tobacco operations that are more than 60 times higher than the entire annual budget of WHO. Even more alarming is that this revenue represents more than 10 times the gross domestic product of a country like Bolivia. Indeed the gross revenue of the largest of these companies, from its international tobacco operations, is equal to the gross domestic product of Bangladesh, a country of 115 million inhabitants; and it represents 100 times the total health budget of Ecuador. Equally unacceptable is the fact that the advertising budget of this company, in the United States alone, is equal to 50 times the total budget of the WHO Tobacco or Health programme. But the industry is losing over 8000 of its consumers every day, which means that, to survive, it must advertise its products to encourage young people to consider smoking as glamorous and socially acceptable behaviour.

POLICY

. . .

When we met in Perth two years ago, I said that WHO had two priorities for tobacco control – that is, in developing countries and among women.

Action in relation to developing countries has been twofold. WHO is striving to protect the populations of these countries from tobacco consumption and its consequences, before epidemic proportions are reached. Even while we meet, the multinational tobacco companies, with their headquarters located in the most developed countries, are investing large amounts of money and expertise in the development of tobacco growing and manufacturing industries in developing countries. This creates economic dependence on the growing of tobacco. And such an expansion of the tobacco industry can only lead to the perpetuation and expansion of the modern epidemic, with the prospect of short-term economic and fiscal returns overshadowing the longer-term returns of health development.

Our attention has also focused on the problems of those developing countries that depend on the production of tobacco as a major source of income for their economic and health development. Development agencies should assist these countries to introduce the necessary economic changes. These would include crop substitution, agricultural diversification and the provision of economic support to generate new sources of income. In July 1991, I myself underlined the importance of tobacco-related issues in my report to the Economic and Social Council of the United Nations. In addition, WHO has pressed for the discussion of these issues in the competent forums of the organizations and bodies of the United Nations system, for example, the governing bodies of FAO, GATT, ILO, UNCTAD, UNIDO and the World Bank, which would need to formulate their own policies. Indeed, the World Bank has recently decided no longer to lend money to activities related to tobacco production.

The consumption of tobacco by women is not yet generally recognized as being a major problem, since their participation in the smoking epidemic is comparatively recent. With a view to sensitizing the world, particularly women, WHO will shortly be publishing a monograph on women and tobacco. For the first time, a global perspective is provided, potential solutions are offered, and the need to investigate certain areas further is underlined.

New public health action is needed as a response to the challenges presented by rapid social, economic and political change; a new paradigm for health whereby its protection and promotion will be the key to development. Tobacco should not be allowed to damage the precarious economic and health equilibrium of the world in which we live. Two years after Perth, I appeal once again for a joining of forces, in a way that already has been successful, so that we can work together for peace and health."

* * *

Dr H. Nakajima also chaired, with Dr C. Guerra de Macedo, a panel of ministers of health of several Latin American countries on the theme "Issues and challenges". During this session they emphasized that although ministers of health have continued to show courage and determination in their struggle for a tobacco-free society, they often find themselves in a dilemma. On the one hand, their colleagues in other ministries may consider tobacco to be a source of employment and revenue for the state; as a result they are less enthusiastic about controlling its consumption. On the other hand, health interest groups may be quick to criticize ministers of health when they feel there is a need for greater action for tobacco control.

Economic forces are at work for increased tobacco consumption. Tobacco consumption is addictive in nature and governments are also addicted to tobacco taxes and the employment generated. In the face of these constraints, ministers of health are often the sole moral conscience and authority for speaking and acting against tobacco use. Numerous examples presented from Latin American countries illustrated that this function was being fulfilled. It was concluded that all those concerned about tobacco or health issues, in whatever sphere they work, should support ministers of health in intensifying tobacco control measures, and praise them for what has already been achieved.

INTERNATIONAL AGENCY FOR RESEARCH ON CANCER

DETERMINANTS OF SMOKING BEHAVIOUR IN GIRLS AND BOYS

(Scientific presentation by Annie J. Sasco, IARC)

A survey on adolescent smoking habits was carried out among 1 152 girls and 1 324 boys, mostly aged between 11 and 16 and belonging to 16 representative schools of the "département" of Rhône in France, using a self-administered, anonymous questionnaire.

The proportion of regular smokers (i.e. smokers of at least one cigarette per week) regularly rose from 5.3% at age 11 to 42% at age 16 among girls and from 8.3% at age 11 to 34% at age 16 among boys. Among never smokers, the main reason for not trying tobacco was the fear of ill effects to health, and almost never lack of opportunity. Ninety per cent of never smokers do not intend to smoke in the future. Among ever smokers, the median age at first cigarette was 12 and the median age at onset of regular smoking was 13. First cigarettes were generally provided by friends and were

tried out of curiosity. Most smokers buy their own cigarettes, which are usually filter-tipped, and inhale. Reasons for carrying on smoking include pleasure, habit, and also stress. Forty-four per cent of smokers would like to stop.

Univariate analyses and logistic regression were used to identify predictors of smoking among triers or regular smokers compared to never smokers. The main determinant of regular smoking corresponds to peer influence, defined as belonging to a group where the majority smoke, and is stronger for girls (OR = 11) than for boys (OR = 8). Similarly, smoking of best friends clearly increases the risk of becoming a regular smoker and, again, is stronger for girls (OR = 13) than for boys (OR = 7). Having parents who are divorced is associated with a statistically significant OR of the order of 2 both for girls and boys, whereas having parents not born in France is linked to a reduced risk. Parental smoking has an impact on children's smoking (crude OR = 2), but controlling for other factors in the logistic model reduces the OR to 1.4 for girls and 1.8 for boys.

HEALTH EDUCATION

COMPREHENSIVE SCHOOL HEALTH EDUCATION: INTEGRATED APPROACH TO TOBACCO PREVENTION EDUCATION

(Conference theme presentation by H.S. Dhillon (WHO), V. Kolybine (UNESCO), and A. Hewitt (UNICEF))

Education for health in schools has been shown to provide a cost-effective way of helping children – a billion children – attending schools to gain knowledge and skills to pursue healthy ways of life. School health education should be comprehensive to be effective.

Comprehensive school health education programmes have a two-fold goal. They not only provide children with health knowledge and skills for pursuing healthy lifestyles, and maintaining and promoting health, but also foster positive values and a sense of responsibility towards oneself and others. The comprehensive approach with a holistic view of interrelated health problems (e.g. tobacco, alcohol, adolescent pregnancies, AIDS) are often not understood very well. WHO, in collaboration with UNESCO and UNICEF, together with the US Centers for Disease Control, Atlanta, teachers' associations and experts in health education, found it useful to organize a Consultation, in November 1991, with a view to reaching a common understanding on the characteristics of effective school health education programmes and on how to go about implementing them. This is to be followed by similar efforts at regional and country levels to further refine strategies and facilitate action.

One outcome of the Consultation are the Guidelines on Comprehensive School Health Education that will soon be ready for distribution. Education and health experts must develop a pragmatic and sequentially organized health curriculm – student-centred, age-appropriate and culture-sensitive. Implementation of this curriculm can only be successful if there is commensurate preparation of teachers and all education officers, managers and supervisors concerned. Also needed are teaching and learning materials for both teachers and pupils. Monitoring application and assessing impact are added essential components to be planned and implemented.

A good number of smokers are introduced to tobacco when they are in school. Many children are exposed to tobacco early in life at home and in their communities. The school as a setting with a sizeable child population group justifies special focus when planning for education against tobacco use.

The available data on the ability of school-based programmes to influence student behaviours are largely in the area of smoking. Children are not only given the required knowledge showing why not to smoke and how tobacco harms one's health but they are helped through social consensus to develop positive attitudes and are given resistance skills training on saying "no" when offered a cigarette. There are also sessions that train children to deal with advertisements in a sensible way by analysing the claims made by promoters of products like cigarettes in an objective way and not to be carried away and influenced by their persuasive ways.

An efficacious smoking prevention curriculum has multiple components, including cognitive and affective components. These include: knowledge about smoking, the prevalence rate and effect on health; critical analysis skills training to handle the advertisements on mass media; parental and peer influence to smoke; peer participation in programme delivery; and peer pressure resistance training including role play and opportunities to practice the skills.

In planning for comprehensive school health education, substance abuse should be a topic that needs careful curriculum development in terms of content and innovative methods of teaching as well as in establishing school-community links.

POLICY

SMOKE-FREE TRANSPORT AND OTHER PUBLIC PLACES

(Luncheon meeting and skills-sharpening session)

At a luncheon meeting hosted by the American and Canadian Cancer Societies, participants were invited to work together to convince airlines, governments and the International Civil Aviation Organization (ICAO) to take measures to move towards smoke-free air travel on all national and international flights. Mr Neil Collishaw (WHO/TOH) and Dr Silvio Finkelstein (ICAO) reminded participants that the World Health Assembly (WHA) had unanimously passed resolution WHA44.26 in May 1991, urging Member States "to ban smoking in public conveyances where protection against involuntary exposure to tobacco smoke cannot be ensured." Moreover, the WHA had requested the WHO secretariat to collaborate with ICAO in developing guidelines for smoke-free air travel. Participants learned that such collaboration was under way. Dr Finkelstein informed participants that ICAO was indeed concerned about tobacco smoke in aircraft, but that its mandate and principal concern was airplane safety. Therefore representations to ICAO should address safety, not health. However, he quickly added that the ongoing collaboration between WHO and ICAO permitted a comprehensive approach to addressing the problem of the presence of tobacco smoke in aircraft.

Participants left the meeting resolved to ensure that all air travellers who will attend the Ninth World Conference on Tobacco or Health in Paris in 1994 will reach their destination on smoke-free flights.

Later in the conference, Mr Collishaw, Dr Finkelstein, Mr Ken Kyle from the Canadian Cancer Society, and Mr Patrick Oshoke from Benue State in Nigeria, chaired a skills-sharpening session entitled *Smoke-Free Transport and Other Public Places*. Many of the themes of how to move towards safe, healthy and smoke-free national and international air travel were again raised. However, the discussion broadened and specific strategies of how to move incrementally towards smoke-free travel in taxis, buses, trains and public places were also addressed. Successful actions to remove tobacco smoke from some airlines and some bus lines in Nigeria were recounted by Mr Oshoke. He also presented information on new tobacco control legislation that provides some controls on tobacco advertising and limits on smoking in public places in that country.

Participants engaged in a lively discussion and exchange of views on how to effectively achieve protection from involuntary exposure to tobacco smoke. They concluded that much can be achieved through local action to have smoking restricted by administrative arrangements or local ordinances. As the circle of smoke-free transport and public places widens, further protection can be achieved through the adoption of state and national legislation guaranteeing smoke-free public places and transit vehicles. In the case of air travel, participants welcomed the challenge of helping to achieve an international regulation to guarantee smoke-free air travel everywhere in the world.

POLICY

THE ROLE OF A MINISTRY OF HEALTH

(Skills-sharpening session with the participation of Dr Menchaca, Programme Manager, WHO/TOH; Dr Manuel Adrianza, former Minister of Health, Venezuela; and Dr Konrad Mmumi, United Republic of Tanzania)

The main role of a ministry of health in the control of tobacco use as an important public health problem was discussed in conjunction with the need for political will to give high priority to tobacco control activities. Although other health problems may appear to be more pressing, it was agreed that action is now required to prevent these problems from being further aggravated by tobacco related diseases, particularly in developing countries.

The minister of health is responsible for the political decision to implement a national tobacco control programme, its policy and strategies, and should assume the leadership of all sectors whose activities are relevant to the problem of tobacco use; the establishment of an interministerial committee to ensure coordination and unity of objectives should also be promoted. The programme should be conceived as a permanent function within the national health system, integrated into the primary health care activities and interrelated with the relevant programmes; however, the programme should keep its own identity as part of the principal functions of the ministry of health, with the necessary resources for the successful development of its activities.

It was emphasized that the ministry of health should seek public support and the active participation of governmental/nongovernmental organizations and key groups, including politicians, health professionals, teachers, women and youth groups.

WORLD NO-TOBACCO DAYS

USING WORLD NO-TOBACCO DAYS TO CONVEY THE MESSAGE

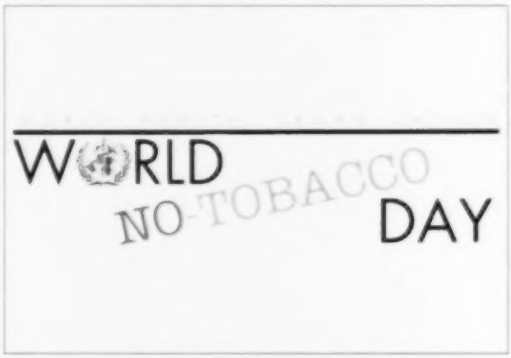
(Skills-sharpening session with the participation of C. Chollat-Traquet (WHO/TOH), P. Kraft (WHO/TOH), P. Schioldborg (Norway), V. El Fehri (Swiss Interagency on Smoking and Health (AT)), N. Islam (ADHUNIK), W. Zatonski (UICC), and G. Dessart (USA))

This skills-sharpening session invited an internationally selected panel to discuss the different approaches adopted for the celebration of World No-Tobacco Day, and the successes realized as a result of this event all over the world.

In adopting resolution WHA42.19 in 1989, the Member States of the World Health Organization took a unanimous decision to celebrate World No-Tobacco Day on 31 May each year and, by the same resolution, asked WHO to coordinate worldwide preparation for and celebration of the day.

What is World No-Tobacco Day? On each World No-Tobacco Day, an appeal is made to those who smoke or chew tobacco to cease for at least 24 hours as a first step towards breaking a harmful and wasteful habit. Consequently, World No-Tobacco Day is primarily concerned with tobacco smoking and chewing cessation. However, it was realized that not only could a continued smoking cessation appeal be regarded as tedious, but that action had to be taken to improve knowledge about the main tobacco or health issues and to attract the attention of national authorities and decision makers, with regard to certain tobacco or health issues; it was thus decided to attribute a **theme** to each World No-Tobacco Day and to highlight crucial information on the threat to health posed by tobacco.

Four years after the first World No-Tobacco Day, the long shelf life of the **materials** distributed by WHO shows the interest in the themes chosen for each year. WHO materials (advisory and press kits, videos, radio recordings, press releases and articles) have been adapted (even "hijacked"!) and translated into various languages in most countries. The fact that all the speakers in the opening session of the Conference referred to this event also shows that World No-Tobacco Day has become an integral part of the international calendar of "yearly celebrations".



Results form **the evaluation of the worldwide celebration** of World No-Tobacco Days in 1989, 1990 and 1991, show that the day was celebrated in all WHO regions, in almost all WHO Member States, and in many United Nations agencies; however, the most important activities took place at the national, regional, and local levels in individual countries. There is every reason to emphasize the role of both national and local health authorities and non-governmental organizations as initiators and organizers of these activities. For example, the celebration of World No-Tobacco Day 1991 ranged from awareness-raising activities to the introduction of essential elements of national tobacco control programmes. In all countries, there was considerable coverage of the day by the mass media; education campaigns were launched; posters, stickers, folders, postcards and other information materials were widely distributed. Tobacco surveys were carried out and smoking cessation clinics were opened. Public transport and public places were declared tobacco-free in many countries.

The very high level of **public awareness** regarding tobacco or health raised on World No-Tobacco Day 1991 contributed to placing this issue high on the list of priorities of politicians and decision makers. This illustrates that the day is a useful tool in terms of promoting the concept of a tobacco-free society and non-smoking as a social norm.

But how successful has World No-Tobacco Day been in getting out the **non-smoking message?** In response, the opinions of smokers on the 1988 World No-Tobacco Day in Norway were analysed. A survey of a representative sample of 1 211 adult Norwegians reported that 96% had observed the day, and that about one-third of smokers had reacted to it. Hence, 5% of the regular smokers did not smoke on World No-Tobacco Day, while 18% reported to have reduced their tobacco consumption. Among occasional smokers, the corresponding proportions were 63% and 7%, respectively. A fortnight later, 2% of the regular smokers still did not smoke, while 9% continued to smoke at a reduced level. Converted into population figures, approximately 240 000 regular smokers did not smoke on the day, while a similar number reduced their smoking. Two weeks later, almost one- half maintained their initial reaction. Compared to the normal quitting rate for regular smokers over a period of 14 days, this was five times higher.

In Bangladesh, the annual success of the celebration of World No-

WORLD NO-TOBACCO DAYS

USING WORLD NO-TOBACCO DAYS TO CONVEY THE MESSAGE

Tobacco Day is mainly due to the fact that from the outset there has been **involvement** by the **highest level of the government,** which has been motivated by a well organized national NGO "ADHUNIK". Once the involvement or the aid of the government had been secured, political leaders and the media joined the movement. This added strength to the campaign, as did the religious leaders who were particularly instrumental in alerting the illiterate masses of the celebration; the print media are understandably ineffective with this section of the population and the electronic media are not widely available. The singing of folk songs and the holding of local discussions with all strata of society also helped to convey the message successfully. As a result of the general involvement of the political sector in these celebrations, all major decisions on tobacco control were taken on or around World No-Tobacco Day. The Bangladesh model shows that World No-Tobacco Day provides a unique opportunity, based on strong political will, to unify the efforts of key people in all walks of life.

World No-Tobacco Day is also seen as an occasion to facilitate coordination between all the actors at the national and international levels of tobacco control and to focus their attention and activities on a specific theme. Switzerland is a country with multiple languages and religions, a number of independent local authorities, and several national and local NGOs. The Swiss Interagency on Smoking and Health (AT) provided an example of how the various activities undertaken in celebrating World No-Tobacco Day by national and local NGOs, and health authorities can be coordinated. Cooperation between all parties involved and the respect given to each participant's contribution enabled Switzerland to enjoy a successful and unified

celebration of World No-Tobacco Day 1991.

Poland has one of the highest rates of tobacco consumption. The Polish Anti-Smoking Society used the occasion of World No-Tobacco Day 1991 to organize a competition aimed at motivating individuals to stop smoking. This competition was conducted in collaboration with the most popular Polish evening newspaper *Ekspress Wieczorny*, with a one-week visit to the United States as the first prize; this visit included a meeting with Senator Edward Kennedy (whose warm letter of invitation was widely published in the Polish press) during the Great American Smokeout (GAS) organized by the American Cancer Society. The competition enjoyed great success for many months (April to November 1991) and it is believed that 6 000 Poles stopped smoking as a result of this activity.

The session then turned to the success stories in getting **maximum media exposure** for World No-Tobacco Days and the **cost/benefit** derived in this field from World No-Tobacco Days. By any measure, the American Cancer Society's World No-Tobacco Day, the annual Great American Smokeout, is a success: the Gallup Poll showed that 83% of all Americans were aware of the 1992 GAS. The poll also showed that more than 35% of all smokers participated, that 7 million of them continued to abstain from smoking for 24 hours, and that nearly 12% of the nation's smokers were still not smoking one to three days later.

This success is greatly due to the amount of free media attention the GAS gets before, during and after the day itself. No anti-smoking campaign could afford to buy the print space or prime-time broadcast slots sufficient to achieve the results seen in 1991. To reach the numbers of people represented by the Gallup Poll figures, a conservative estimate suggests that, at the minimum, a four-week advertising campaign would be required and advertisers would have paid out a grand total of more than US $ 16 million for the four-week long campaign. Similar calculations could be made in other countries with the appropriate local factors, such as the number of television households, the cost of advertising, etc.

This is, of course, only looking at some of the results of World No-Tobacco Days. It is virtually impossible to quantify the effect of publicity on school children, the value of the advice given by various experts incidental to the event, or the value of information concerning all aspects of tobacco control issues.

But clearly, in an evaluation of the benefits of the day, the most important figure will be the additional number of years of tobacco-free life World No-Tobacco Day may help in assuring for tobacco users who quit, their families, and those who share their workplaces.

WHO PROGRAMME

WHO REGIONS: VERY ACTIVE IN THE BUENOS AIRES CONFERENCE

As early as mid-1991, preparation for the Eighth World Conference on Tobacco or Health had begun in all the WHO regional offices. Not only did they circulate invitations within their regions and identify individuals who could make a valuable contribution to the Conference, but they also endeavoured to find funds to pay for the participation of several national focal points for tobacco control, e.g. the WHO Regional Office for South-East Asia, financed the attendance of nine participants. These focal points presented scientific papers at the Conference and conveyed the point of view of developing countries, showing how the tobacco control movement could be very active even in countries where health priorities, such as communicable diseases, were still a major problem. In addition to financially supporting nationals, two regional offices sent regional advisers to contribute personally to the Conference: Dr E. Nicholls, Regional Adviser for Noncommunicable Diseases in AMRO/PAHO (see page 4 of this issue of *Tobacco Alert*), and Dr M. Al Khateeb, the Regional Adviser for Health Education and Health Promotion in the WHO Regional Office for the Eastern Mediterranean (EMRO), who presented two papers on smoking trends and the economic effects of tobacco consumption in the region.

This active involvement by the WHO regional offices will continue long after the Conference, through the distribution of Conference papers and recommendations to the tobacco or health focal points in most countries.

EPIDEMIOLOGY

TOBACCO MORTALITY: PRESENT AND FUTURE (General session)

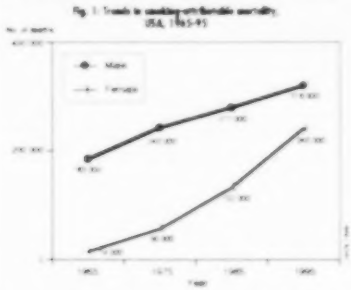
Dr Alan Lopez (WHO/TOH) and Dr Richard Peto from Oxford University, Chairman of WHO's Consultative Group on Tobacco-Related Mortality, gave an overview at the opening session of the Eighth World Conference on the present and future burden of tobacco-induced illnesses. According to their estimates, the annual death toll from tobacco use has risen from about 1 million in the mid-1960s to about 3 million currently. This mortality, on present consumption trends, is expected to rise to about 10 million by the mid-2020s, 70% of which will occur in developing countries. By this time, tobacco use is projected to account for about 15% of all deaths in the developing world. The estimates are summarized in Table 1.

Table 1: Annual deaths attributed to tobacco, 1965, 1995 and 2025

	Annual tobacco deaths (in millions)		
	1965	1995	2025
Developed countries	0.9	2	~3
Less developed countries	0.1-0.2	~1	~7
World	~1	3	~10

Source: WHO estimates

Although much of the projected increase in tobacco-related mortality will occur in the developing world, annual smoking-related deaths in developed countries are projected to rise by 50% over the next 30 years. Much of this increase will occur among women as the full effects of the rapid increase in smoking among females become evident. In countries such as the United Kingdom and the United States, where women first began to smoke in large numbers, annual tobacco-related mortality is rapidly approaching that of men. The trends for the United States are illustrated in Figure 1. The annual number of female smoking-attributable deaths has risen from about 14 000 in 1965 to about 240 000 projected for 1995. This represents about three-quarters of the expected number of male smoking-related deaths in the United States in



1995 and about half of all female smoking-attributable deaths expected to occur in that year throughout the developed world (510 000). Moreover, on current trends, the annual smoking-attributable mortality for females is expected to exceed that of males in the United Kingdom and the United States sometime between 2005 and 2010.

In the 1990s, smoking is estimated to kill about 2.1 million adults each year in the developed countries, 1.6 million of whom are men. In middle age (i.e. 35-69 years), the annual number of male smoking deaths is almost 1 million (940 000), or about 40% of all deaths in middle aged men. Smoking is both absolutely and proportionately less important as a cause of death among elderly men (aged 70 years and over), among whom some 680 000 or 23% of all deaths succumb each year due to smoking. Even within Europe, there are significant variations in the pattern of smoking-attributable mortality. In the European Community (EC), for example, smoking kills an estimated 570 000 people each year, 465 000 of whom are men. Of these men, 220 000 die before the age of 70 years, with smoking being responsible for 36% of male deaths at ages 35-69 years. Although female mortality from smoking in the EC is still somewhat lower (105 000 deaths a year) compared with males, this toll is expected to increase dramatically over the next two or three decades.

In Eastern Europe, the impact of past smoking trends is already overwhelming. The probability of a 35 year-old man dying in middle age (i.e. before 70 years) in countries such as Czechoslovakia, Hungary, Poland and the former USSR, is about 50%, half of which can be attributed to tobacco. In these four populations alone, smoking currently claims 590 000 male lives each year, 450 000 or 75% of which are in middle age. These men lose, on average, about 20 years of life expectancy. Conversely, among women in these countries, smoking has been less prevalent, particularly among older women, with the result that the smoking attributable fraction in middle age typically varies from 7-14%. This is substantially lower than the proportionate mortality from smoking in middle-aged women in the USA (37%), Canada (34%), the United Kingdom (29%), and New Zealand (28%), where female smoking has been prevalent for decades. However, in many developed countries, smoking prevalence among younger women is now comparable, if not higher than that for young men, and if these women become persistent smokers, their smoking-attributable mortality rates will rise accordingly.

For the developed countries as a whole, the annual number of smoking-attributable deaths was estimated at about 0.9 million in 1965, 1.3 million in 1975, 1.7 million in 1985 and projected to be about 2.1 million in 1995. In terms of cumulative mortality, smoking has been the cause of at least 50 million deaths in the developed countries since 1950 and, on current trends, is projected to kill another 100 million people in these countries over the next four decades, most of whom are alive today.

This newsletter is issued by the WHO programme on Tobacco or Health (TOH), World Health Organization, 1211 Geneva 27, Switzerland. The text may be freely reproduced and illustrations may be used, giving credit to WHO. Cuttings are requested. Contributions and suggestions to be addressed to Dr C. Chollat-Traquet, Editor.

In addition to the names indicated at the beginning of each article, the following WHO headquarters staff have contributed to this issue:

- *S. Ewart, J.-C. Fattier, T. Farkas.*

Design WHO Graphics